STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 00 B. WING	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE VILLAGE	7510 ROSEGATE DR INDIANAPOLIS, IN 46237

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F0000	This visit was for Investigation of Complaint IN00111252. Complaint IN00111252 Unsubstantiated due to lack of evidence. Unrelated deficiencies cited Survey dates: July 11 & 12, 2012 Facility Number: 011149 Provider Number: 155757 AIM Number: 200829340 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 38 SNF/NF: 107 Total: 145 Census Payor Type: Medicare: 36 Medicaid: 78 Other: 31 Total: 145 Sample: 4 Supplemental sample: 30	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/18/12 by Suzanne Williams, RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure the resident's plan of care was followed, in that when a resident had a history of falls, and a plan of care was developed, the nursing staff failed to implement the plan of care in regard to safety assistive devices for 1 of 3 residents reviewed for falls in a sample of 4. [Resident's "B"] Findings include: The record for Resident "B" was reviewed on 07-11-12 at 11:50 a.m. Diagnoses included, but were not limited to, cataracts, coronary artery disease, anxiety, depression, diabetes, hypertension, hallucinations and senile dementia with delusions. These diagnoses remained current at the time of the record review. The most recent fall risk assessment, dated 06-20-12 indicated the resident had a history of falls within the past three months, was incontinent of bowel and bladder, had impaired vision, is confused, disoriented, used a walker and had an impaired gait/balance."	F0282	F282 Our facility strives to provide the best care possible. In accordance with that policy we have addressed the following issue. 1) · Resident "B" had non-skid strips placed by the left side of the bed, in front of the recliner and in front of the commode on 7/12/12 at 10:55A.M. 2) · All residents have the potential to be effected by this deficient practice. Residents at risk for falls have fall interventions in place. IDT reviewed all fall interventions on 7/13/12 to ensure all environmental fall interventions were in place. 3) · Facility Interdisciplinary Team (IDT) will review policies and procedures on *Fall Management Program*. · An in-service with post test for customer care representatives, IDT, and nurses was completed by 8/5/12 by ED/DNS/Staff Development Coordinator/Designee regarding *Fall Management* which includes but is not limited to care	08/06/2012

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	The current plan of care, originally dated 11-22-11 indicated the resident was at "risk for fall due to history of falls, dementia, delusion, hallucination, unsteady gait and forgets to use walker." Approaches/interventions to this plan of care included a "bed alarm, call light within reach, a chair alarm, non skid footwear, the walker within reach, a scoop mattress, and non skid strips to floor by bed, recliner and commode." During observation on 07-11-12 at 10:15 a.m., the resident's room lacked the interventions of the non skid strips in front of recliner and in front of the commode. An additional intervention noted as "FYI [for your information] and dated 07-11-12, in the resident's record included "non skid strips to the left side of the resident's bed." On 07-12-12 at 10:45 a.m., the Director of Nurses verified the strips in front of the recliner and commode were not in place, and the additional "FYI" for strips to the left side of the resident's bed also had not been implemented. 3.1-35(g)(2)		plan development and implementation of interventions. · Director of Nursing Services (DNS)/Designee will be notified of all falls and inquire what the immediate fall intervention was put into effect. Nurses are responsible for the immediate intervention and documentation of the intervention in the ASC Fall Event and temporary care plan. · All falls will be discussed by the IDT the next business day and the weekend supervisor or manager of the day will review all falls to ensure implementations of continued and new interventions. · Fall risk assessments and care plans are completed upon admission and no less than quarterly based on the *Resident Assessment Instrument (RAI).* · Customer Care representatives/Nurse Manager on Duty will be given copies of their customer care rooms fall care plans so they can ensure environmental interventions are in place during rounds. New fall care plans will be distributed weekly with care plan schedule and as needed. 4) · The MDS Coordinator/Qualified Designee is responsible for the completion of the Fall Management CQI audit tool weekly for four weeks, then bi-monthly for two months, then	

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			quarterly for two cycles and results reported to the CQI committee over seen by the Executive Director if threshold of 95% is not achieved action plan will be developed to ensure compliance.	

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of a resident in that when a resident was identified as a fall risk and had a recent fall with a significant head injury, the nursing staff failed to ensure the non skid strips had been placed in specific sections of the resident's room, to aid the resident's gait/balance. This affected 1 of 2 residents who fell and sustained injury in a sample of 4. [Resident "B"] Findings include: The record for Resident "B" was reviewed on 07-11-12 at 11:50 a.m. Diagnoses included, but were not limited to, cataracts, coronary artery disease, anxiety, depression, diabetes, hypertension, hallucinations and senile dementia with delusions. These diagnoses remained current at the time of the record review. The most recent fall risk assessment, dated 06-20-12, indicated the resident had a history of falls within the past three	F0323	F323 Our facility strives to provide the best care possible. In accordance with that policy we have addressed the following issue. 1) · Resident "B" had non-skid strips placed by the left side of the bed, in front of the recliner and in front of the commode on 7/12/12 at 10:55A.M. 2) · All residents have the potential to be effected by this deficient practice. Residents at risk for falls have fall interventions in place. IDT reviewed all fall interventions on 7/13/12 to ensure all environmental fall interventions were in place. 3) · Facility Interdisciplinary Team (IDT) will review policies and procedures on *Fall Management Program*. · An in-service with post test for customer care representatives, IDT, and nurses was completed by 8/5/12 by ED/DNS/Staff Development Coordinator/Designee regarding *Fall Management* which includes but is not limited to care	08/06/2012

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	months, was incontinent of bowel and bladder, had impaired vision, was confused, disoriented, used a walker and had an impaired gait/balance. The current plan of care, originally dated 11-22-11, indicated the resident was at "risk for fall due to history of falls, dementia, delusion, hallucination, unsteady gait and forgets to use walker." Approaches/interventions to this plan of care included a "bed alarm, call light within reach, a chair alarm, non skid footwear, the walker within reach, a scoop mattress, and non skid strips to floor by bed, recliner and commode." During the initial tour of the facility on 07-11-12 at 9:50 a.m., with Licensed Nurse employee #5 in attendance, the resident was identified by the nurse as having a "recent fall." The Licensed Nurse indicated the resident "fell last night or really this morning at 5:25 a.m. while [resident] was walking. There is a raised bump on the back of the right side of the head, and [resident] has had an increase in blood pressure since the fall." During observation on 07-11-12 at 10:30 a.m. while the resident was seated in a recliner, the Licensed Nurse moved the resident's hair away from the raised area. The head had a large hematoma on the		plan development and implementation of interventions. · Director of Nursing Services (DNS)/Designee will be notified of all falls and inquire what the immediate fall intervention was put into effect. Nurses are responsible for the immediate intervention and documentation of the intervention in the ASC Fall Event and temporary care plan. · All falls will be discussed by the IDT the next business day and the weekend supervisor or manager of the day will review all falls to ensure implementations of continued and new interventions. · Fall risk assessments and care plans are completed upon admission and no less than quarterly based on the *Resident Assessment Instrument (RAI).* · Customer Care representatives/Nurse Manager on Duty will be given copies of their customer care rooms fall care plans so they can ensure environmental interventions are in place during rounds. New fall care plans will be distributed weekly with care plan schedule and as needed. 4) · The MDS Coordinator/Qualified Designee is responsible for the completion of the Fall Management CQI audit tool weekly for four weeks, then bi-monthly for two months, then	

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	posterior right upper section of the resident's head and was deep purple in color. Review of the facility "Event Report," on 07-12-12 at 8:55 a.m. and provided by the Director of Nurses, indicated on 07-11-12 the resident was "found on the floor in room lying on "R" [right] side, non skid socks on and pajama gown. Nursing <sic> appeared to be headed to the rest room, walker was next to bed. ROM [range of motion] +, pupils reactive, has raised area to back of head on right side. Responds to name and touch, Spoke with [name of individual at physician's office] about fall and vitals, no new orders. Nursing staff is to monitor resident closely for any changes in BP [blood pressure] and to the raised area." During observation on 07-11-12 at 10:15 a.m., the resident's room lacked the interventions of the non skid strips in front of recliner and in front of the commode. An additional intervention noted as "FYI" [for your information] and dated 07-11-12, in the resident's record included "non skid strips to the left side of the resident's bed." On 07-12-12 at 10:45 a.m., the Director		quarterly for two cycles and results reported to the CQI committee over seen by the Executive Director if threshold of 95% is not achieved action plan will be developed to ensure compliance.	

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	of Nurses verified the strips in front of recliner and commode were not in place, and the additional "FYI" for strips to the left side of the resident's bed also had not been implemented. The facility "Fall Management Program," provided by the Director of Nurses on 07-11-12 at 2:30 p.m. indicated the following: "POLICY [bold type] It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls." "PROCEDURE - Fall Risk. A fall risk assessment will be completed upon admission, re-admission, quarterly, annually and with a significant change in condition." "Post Fall - 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and provide necessary treatment. 2. If the resident experienced an injury from the fall, contact facility DNS [Director of Nursing Services] / ED [Executive Director] per facility protocol. 3. The			

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	family will be notified by the charge nurse of all falls. 4. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide "immediate interventions [bold type]." 3.1-45(a)(2)			